STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

AND

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

JOHN DEERE HEALTH PLAN, INC.

MOLINE, ILLINOIS

FOR THE PERIOD JANUARY 1, 2001,
THROUGH JUNE 30, 2001

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DATE: March 21, 2003

A Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of John Deere Health Plan, Inc., 408 North Cedar Bluff Road, Suite 400, Knoxville, Tennessee, 37923, was completed April 10, 2002. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of John Deere Health Plan, Inc. ("JDHP") for its TennCare line of business.

Further, this report reflects the results of a limited scope review of financial statement account balances as reported by JDHP as they relate to the TennCare line of business. This report also reflects the results of a compliance review of JDHP's policies and procedures related to statutory and contractual requirements.

A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of JDHP was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the TennCare contract between the State of Tennessee and JDHP (the TennCare contract), Executive Order No. 1 dated January 26, 1995, and Tenn. Code Ann. § 56-32-215.

JDHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Bureau within the Tennessee Department of Finance and Administration administers the TennCare Program.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of JDHP for its TennCare line of business. The examiners randomly selected 30 claims for testing from paid and denied claims processed for TennCare enrollees by JDHP during each of the months of January 2001 and April 2001 for a total of 60 claims. The fieldwork was performed using records obtained via an onsite examination of records from November 26, 2001, through November 29, 2001, and via the US Postal Service from November 23, 2001, through February 20, 2002.

The limited scope financial examination focused on the TennCare income statement as reported by JDHP on its National Association of Insurance Commissioners'

(NAIC) Quarterly Statements for the quarter ended June 30, 2001, the Medical Loss Ratio Report filed by JDHP as of June 30, 2001, and a review of the Risk Banding Option for the period ended June 30, 2001.

The limited scope compliance examination focused on JDHP's provider appeals procedures, review of provider agreements and subcontracts, and demonstration of compliance with Federal Title VI of the 1964 Civil Rights Act and the Insurance Holding Company System Act of 1986.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that JDHP's TennCare operations were administered in accordance with the TennCare contract and state statutes and regulations concerning HMO operations and that JDHP TennCare members received uninterrupted delivery of health care services.

The objectives of the examination were to:

- Determine whether JDHP met its contractual obligations under the TennCare contract and whether JDHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq*.;

- Determine whether JDHP had sufficient financial capital and adequate risk reserves to ensure the uninterrupted delivery of health care services for its TennCare members on an on-going basis;

- Determine whether JDHP properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether JDHP had implemented an appeal system to reasonably resolve appeal from TennCare providers in a timely manner; and

- Determine whether JDHP had corrected deficiencies outlined in prior reviews of JDHP conducted by the Comptroller and examinations conducted by TDCI.

III. PROFILE

A. Administrative Organization of JDHP

Heritage National Healthplan, Inc. ("HNHI"), an Illinois HMO, was incorporated under the laws of the State of Illinois on August 5, 1985, and was licensed as an HMO by the State of Illinois Department of Insurance in 1985. HNHI was licensed as an HMO by the State of Tennessee Department of Commerce and Insurance on

June 20, 1995. HNHI is a wholly-owned subsidiary of John Deere Health Care, Inc., (JDHC) which is a wholly-owned subsidiary of Deere & Company (Deere).

Heritage National Healthplan of Tennessee, Inc. ("HNHT"), a Tennessee Health Maintenance Organization ("HMO"), was incorporated under the laws of the State of Tennessee on October 25, 1985, and was thereafter licensed as an HMO by the State of Tennessee Department of Commerce and Insurance on July 1, 1986. Under its license, HNHT administered commercial plans and also participated as a contracted HMO in the TennCare program.

On September 10, 1996, Heritage National Healthplan of Tennessee, Inc., submitted to the State of Tennessee Department of Commerce and Insurance a proposed plan to merge with and into Heritage National Healthplan, Inc. On November 18, 1996, the merger of HNHT with and into HNHI was approved by the Commissioner of the Tennessee Department of Commerce and Insurance to be effective December 31, 1996.

The officers and board of directors for JDHP at December 31, 2001, were as follows:

Officers for JDHP

Richard Lowell Bartsh, M.D., President
Charles Phillip Parsons, Vice President
David Wayne Anderson, Vice President
Bruce Chase Steffens, M.D., Vice President
Daniel Cyril McCabe, Treasurer
Victoria Jane Graves, Secretary

Board of Directors for JDHP

Daniel Cyril McCabe	Charles Phillip Parsons
Richard Lowell Bartsh, M.D.	James Edward Hecker
William Kenneth Appelgate	John Willard Golden, M.D.
Cathie Sue Whiteside	Bruce Chase Steffens, M.D.
Jon Alan Chapman	Victoria Kauzlarich
Charlotte Hershberger Koenig, M.D.	

B. Brief Overview

Beginning in January 1994, HNHT participated in the state's TennCare program. When HNHT merged with HNHI on December 31, 1996, HNHT's TennCare contract was assigned to HNHT. Effective July 1, 1999, HNHI changed its name to

John Deere Health Plan, Inc. JDHP is managed by John Deere Health Care, Inc., pursuant to a service agreement.

JDHP is currently authorized by TDCI and the TennCare Bureau to participate in the TennCare program in the Eastern Grand Region. JDHP derives most of its total revenue in the form of premium payments from its commercial line of business. As of June 30, 2001, JDHP received 16.8% of its 2001 nationwide revenue and 40.0% of its 2001 Tennessee revenues from capitation payments from the State of Tennessee for providing medical benefits to TennCare members. As of June 30, 2001, JDHP had 51,891 TennCare members.

C. Claims Processing Not Performed by MCO

During the period under examination, JDHP subcontracted with the following vendors for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- Doral Dental for dental services, and
- Davis Vision for vision services.

Because subcontractors processed the claims for these benefits, claims for these types of services were not included in JDHP's pool of claims from which claims were selected for testing. Therefore, no dental or vision claims were tested for compliance with the TennCare contract and Tenn. Code Ann. § 56-32-226 ("the Prompt Pay Act").

IV. PREVIOUS EXAMINATION FINDINGS

A. TDCI Examination

The Tennessee Department of Commerce and Insurance, TennCare Division, cited the following claims processing and internal control deficiencies in its prior examination of JDHP for the period October 1, 1999, through December 31, 1999:

1. JDHP did not process all claims selected for testing in accordance with the TennCare contract. Only 44 of 50 claims in the sample were processed within 60 days. Furthermore, in April 2001, JDHP did not process all claims within 60 days of receipt. The TennCare contract requires an MCO to process 100% of all claims within 60 days.
2. One of the 26 paid claims was not paid in accordance with the information on the payment system.
3. One claim was processed for a person who was not a JDHP enrollee.
4. JDHP did not apply the 180 day timely filing requirement to hospital claims.

5. The current pend report identified 12 claims that had been in JDHP's possession for more than 60 days.
6. The explanation of benefits ("EOBs") provided to enrollees did not agree with the information recorded in the claims processing system for 4 of the 5 EOBs selected for testing.
7. The written notice of the results of the claims adjudication given to providers did not agree with the information recorded in the claims processing system for 4 of the 5 EOBs selected for testing.
8. Six of the claims were not stamped with the date received.

The deficiency labeled above as number 8 is repeated in this report.

B. Comptroller's Examinations

The Comptroller of the Treasury, Department of Audit, Division of State Audit, cited the following claims processing and internal control deficiencies in the examination of JDHP for the period January 1, 1998, through December 31, 1999:

1. JDHP improperly denied 6 claims.
2. JDHP incorrectly paid 8 claims.
3. For 7 claims reviewed, not enough information was provided to determine if the claim was properly adjudicated. JDHP's pharmacy subcontractor processed these claims.
4. Nineteen incorrect EOBs were provided to the TennCare enrollees.
5. JDHP failed to pay 100% of all clean claims tested within 40 days of receipt.

The deficiency labeled above as number 3 is repeated as part of this report.

V. SUMMARY OF PERTINENT FACTUAL FINDINGS

A. Summary of Deficiencies – Financial

1. Medical expenses on the exigency report and the medical loss ratio report were not correct.

B. Summary of Deficiencies – Claims Processing

1. The denial reason for 1 of 7 properly denied claims was incorrect.

2. For 11 of 53 paid claims reviewed, not enough information was provided to determine if the claim was properly adjudicated. JDHP's pharmacy subcontractor processed these claims.

3. There is no coordination between JDHP's two out-of-pocket accumulators.

4. The information recorded in JDHP's claims system for 5 of the 60 claims tested did not contain all of the required elements.

5. The claim date received in the claims processing system was not always correct.

6. JDHP did not establish immediate control of claims in the mailroom.

C. Summary of Deficiencies - Other

1. The weekly claims processing report submitted to the TennCare Bureau was not completed properly.

2. The documentation maintained for provider appeals was inadequate.

3. JDHP's pharmacy provider agreement was not in compliance with the TennCare contract.

4. JDHP's subcontracts were not in compliance with the TennCare contract.

5. JDHP's procedures for monitoring subcontractor claim processing and Title VI compliance with the TennCare contract were inadequate.

6. JDHP .did not always pay its subcontractor in a timely manner as required by the subcontract.

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial analysis

As a managed care organization licensed in the state of Tennessee, JDHP files annual and quarterly statements with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if JDHP meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash if necessary to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses should not be included in the determination of plan assets and should not be considered when calculating an entity's total capital and surplus.

As of June 30, 2001, JDHP reported $150,014,266 in admitted assets, $83,614,899 in liabilities and $66,399,367 in capital and surplus on its NAIC quarterly statement.

Although JDHP operates multiple lines of business in multiple states, this examination focuses on the TennCare line of business. JDHP reported total TennCare revenues of $45, 479,451 and total expenses of $49,025,954, resulting in a net loss of $3,546,503 for the 6 months reported. TennCare revenue was composed of $45,369,930 in capitation payments from the TennCare Bureau and $109,521 in contractual recoveries. The program reported $46,115,769 in medical expenses and $2,910,185 in administrative expenses (including income taxes).

1. Capital and Surplus

   Tenn. Code Ann. § 56-32-212 (a)(2) requires John Deere to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150,000,000 of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150,000,000 for the prior calendar year. John Deere's nationwide premiums per the 2000 Annual NAIC statements, Schedule T totaled $463,164,597; therefore, the current minimum statutory net worth requirement is $10,697,469. John Deere's reported capital and surplus was $55,701,898 in excess of the net worth required by the statute.

2. Restricted Deposit

   Tenn. Code Ann. § 56-32-212 (b)(3) requires all HMOs licensed in the state to maintain a deposit equal to one hundred thousand dollars ($100,000) for each ten million dollars ($10,000,000) or fraction thereof of annual premium revenue in excess of twenty million dollars ($20,000,000) and less than one hundred million dollars ($100,000,000) as reported on the most recent annual financial statement filed with TDCI, plus fifty thousand dollars ($50,000) for each ten million dollars ($10,000,000) or fraction thereof of annual premium revenue in excess of one hundred million dollars ($100,000,000) as reported on the most recent annual financial statement filed with TDCI.

   JDHP's contractual deposit requirement at June 30, 2001, was $2,200,000. JDHP provided TDCI with the necessary safekeeping receipt documenting deposits totaling $3,300,000 that have been pledged for the protection of the enrollees in the State of Tennessee.

3. Contractor's Management Fee

   Under the TennCare contract in effect during the examination period, JDHP was allowed to incur administrative cost equal to $13 per member per month (pmpm) to fund administrative expenses plus an additional 2% of TennCare capitation for premium tax expenses. JDHP then transferred the $13 pmpm fee to its parent company, JDHC, in exchange for administrative services.

B. Exigency Provision

On July 1, 2000, JDHP submitted to the Bureau of TennCare a letter of intent to exit the TennCare Program effective December 31, 2000. The TennCare Bureau then exercised the exigency provision of the TennCare contract requiring JDHP to remain in the TennCare program until June 30, 2001 on a "no risk" basis. Effective January 1, 2001, JDHP executed amendment 14 to the TennCare contract. This amendment set forth the requirements for the exigency program.

After the completion of the exigency period, JDHP was required to file a final reconciliation of its premiums and expenses. This reconciliation was to be reviewed by Deloitte & Touche and then submitted to the TennCare Bureau. The report issued by Deloitte & Touche concerning the verification of JDHP's reconciliation was submitted to the Bureau with a letter dated December 27, 2001. Deloitte & Touche found no material errors or omissions in the final reconciliation.

The final reconciliation indicated that JDHP's expenses exceeded premiums and investment income by $3,271,082. During the course of the examination, it was determined that medical expenses erroneously included administrative expenses of $148,407 paid to subcontractors. Since the maximum allowable administrative expenses had already been claimed, total allowable expenses were overstated by $148,407.

On July 1, 2001, JDHP re-entered the TennCare Program under risk banding option 2 whereby JDHP and the state shared in the financial risk for the cost of medical services.

C. Medical Loss Ratio

Section 3-10(c)(1) of the TennCare contract required all TennCare MCOs "to achieve an annual medical loss ratio of no less than 85% of capitation payments received from TENNCARE based on a calendar year as an accountability measure for Fiscal Year 2001 while new accountability measures are being developed. . . .The intent of the 85% medical loss ratio is that 85% of the capitation rate will be spent on covered medical services for eligible TennCare enrollees."

Per the Medical Loss Ratio ("MLR") reports submitted to the TennCare Bureau, JDHP reported an MLR in excess of 85%. A review of documentation supporting payments to capitated subcontractors revealed that payments to these subcontractors included payments for some administrative services. This portion of the payment was included in the calculation of the MLR as capitated medical services. The MLR report should include only payments for medical expenses. This is the same error described above in the exigency section.

Management's comments: John Deere Health concurs with this finding. We have made adjustments accordingly to our reporting, and have corrected the oversight.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Claims Selected For Testing

JDHP provided a data file of paid and denied claims for the months January 2001 and April 2001. The total amount paid per the data file was reconciled to the JDHP check registers and debit memos issued for the respective accounting periods to within an acceptable level. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment. From each data file, 30 claims were selected for use in adjudication accuracy testing and other tests described below.

Of the 60 claims tested, 53 were paid and 7 were denied.

B. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-226(b) and Section 2-18 of the TennCare contract. This statute and the contract required that 90% of all claims be processed within 30 days and 99.5% of all claims be processed within 60 days. The term "process" means that the MCO must either:

- Pay the claim (the MCO shall either send the provider cash or cash equivalents in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by the provider to the MCO);

- Deny the claim, with **all specific reasons** for the denial communicated to the provider; or

- Advise the provider that there is insufficient information to adjudicate the claim and detail the specific information needed to adjudicate the claim.

On August 9, 2001, November 2, 2001, and January 29, 2002, TDCI requested a data file from the TennCare MCOs containing all claims processed during the months of July 2001, October 2001, and January 2002 respectively. Each set of data was tested in its entirety for compliance with the prompt pay requirements of the TennCare contract. Because these tests were performed on all claims processed in July 2001, October 2001 and January 2002, no projections to the population are needed.

During the month of July 2001, JDHP processed 96.54% of all claims within 30 days and 99.74% of all claims within 60 days. During the month of October, JDHP processed 98.13% of all claims within 30 days and 99.85% of all claims within 60 days. During the month of January, JDHP processed 92.33% of all claims within 30 days and 99.77% of all claims within 60 days.

JDHP was in compliance with Tenn. Code Ann. § 56-32-226(b) for claims processing timeliness requirements in the months of July 2001, October 2001, and January 2002.

Note: The sample size used in this step of the examination was not determined statistically; therefore, the results of the timeliness test for processing clean claims could not be projected to the total population of claims processed during the examination period from January 1 through June 30, 2001. The results are valid only for the months of July 2001, October 2001 and January 2001.

C. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied or rejected. Results of the adjudication testing are as follows:

Of the 53 paid claims, all 53 were correctly paid.

All 7 denied claims were appropriately denied. However, 1 appropriately denied claim contained an invalid denial reason. The denial reason was "John Deere Health Care does not coordinate with Medicare under your benefit plan." All TennCare plans should coordinate with Medicare. (034337375)

Management's comments: John Deere Health concurs with this finding.

D. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments allowed for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts were calculated correctly.

All 53 paid claims were tested for pricing accuracy in accordance with the claims processing system price rules. Of the 53 paid claims tested, 11 claims were judgmentally selected to confirm that they were accurately priced according to the executed provider contracts. Only 8 of the 11 claims chosen were for contracted providers and all 8 claims priced according to their respective provider contracts. The other 3 claims chosen were for non-contracted providers. All 3 claims were paid

in agreement with the fee schedule for non-contracted providers.

Of the 53 paid claims tested, 11 were for pharmacy services. Not enough information was provided to determine if these 11 claims were accurately priced. These claims were processed by JDHP's pharmacy subcontractor. Due to the frequent and continual update of pharmaceutical cost in the system and the lack of historical pricing information in the system, the examiners were unable to determine if the correct price was paid for the date of service of the claims tested. (R10850U8J, R108514HR, R10851HTJ, R109601TU, R109608LM, R10960TSZ, R10960Z42, R109613L7, R10961EAY, R110601CM, R110601H0)

Management's comments: John Deere Health concurs with this finding.

E. Withhold, Deductible and Coinsurance Testing

1. The purpose of withhold testing is to determine whether the amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. The withhold amounts are based on a contractual agreement between JDHP and its providers allowing JDHP to retain a percentage of the claims payment to assist in managing care.

   Of the 60 claims tested, 31 were subject to provider withholds and were accurately calculated. Of the 31 claims tested with provider withholds, 7 claims were compared to the executed provider contract. All of the provider withholds applied in the 7 claims tested matched the withhold amounts allowed in the provider contracts.

2. The purpose of deductible and coinsurance testing is to determine whether the claims were processed in accordance with Section 2-3.i. of the TennCare contract; specifically, whether enrollees were subject to out-of-pocket payments on certain procedures, out-of-pocket payments were within liability limits and out-of-pocket payments were accurately calculated.

   Of the 60 claims tested, 8 were subject to deductibles and/or coinsurance. All of the deductibles and coinsurance relative to the 8 claims were within out-of-pocket liability limits.

3. Tests of the out-of-pocket accumulators in JDHP's claims processing system revealed that there were two different accumulators prior to 5/1/01. There was an out-of-pocket accumulator for all medical claims and one for all pharmacy claims. The two accumulators were not integrated to calculate the total out-of-pocket liability, allowing the potential for enrollees to exceed their annual out-of-pocket limitation.

Management's comments: John Deere Health concurs with the finding, but believes that with supplemental processes put in place we are today sufficiently and accurately able to reflect out of pocket expenses to the Bureau. While there is no direct connection between the two out-of-pocket accumulators, John Deere Health does have a process in place to reconcile both systems and accurately report total cost-sharing to the Bureau. The combined out-of-pocket accumulator system was instituted in May 2001.

F. Suspended/Unprocessed Claims Testing

The purpose of testing suspended claims is to determine the existence of claims that have been suspended or pended by JDHP, the reasons for suspending the claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. JDHP provided the examiners a HCFA and UB pended claims report as of October 31, 2001. JDHP reported a total of 17,340 pended claims of which 31 (0.18%) were over 60 days old. Of the 31 claims, 29 claims were less than 90 days old, and 2 claims were aged at 365 days old. A review of the 2 claims aged at 365 days old indicated that the date might have been incorrectly keyed.

The small number of claims on the pend report suggests that JDHP did not have a material unrecorded liability at October 31, 2001.

G. Explanation of Benefits ("EOB") Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductible and coinsurance are provided an explanation of benefits in accordance with usual and customary health care industry practices.

JDHP provides EOBs to all its enrollees. The examiners requested EOBs for all 60 claims tested. In response to this request, JDHP provided 59 EOBs. JDHP failed to provide 1 of the requested EOBs. (H03481283) No discrepancies were noted between the information recorded in the claims processing system and the information reported on the EOB.

H. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

Tenn. Code Ann. § 56-32-226(b) requires an HMO to pay 90% of claims within 30 days of receipt and to process, and if appropriate, pay 99.5% of claims within 60 days of receipt. Tenn. Code Ann. § 56-32-226(b)(1)(B) states that "process" means the HMO will send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally denied and specify all known reasons for the denial.

Remittance advices were requested for 11 of the 60 tested claims to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the related information communicated to the providers for 9 of the remittance advices reviewed. JDHP did not generate a remittance advice for 2 denied claims. However, the information on the remittance advice sent to the provider, including the denial reasons, matched the data in the claims processing system.

I. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by JDHP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for 9 of the 53 paid claims tested. Only 8 cancelled checks were provided by JDHP. JDHP was unable to locate 1 of the requested cancelled checks. (R110601CM) These checks cleared the bank within 12 days of issuance by JDHP.

J. Comparison of Actual Claim with System Claim Data

Original hard copy claims were requested for the 34 claims of the 60 claims tested that were not filed electronically by the providers. (Refer to Section VI.K. below.) The information reported on the hard copy claims was compared to the claims information entered into the claims processing system. For the twenty-six electronic claims, the data submitted was compared to the information in the claims processing system. Of the 60 claims reviewed, 5 did not contain all of the required data elements in the claims processing system. JDHP is required to capture up to 5 diagnosis codes as listed on the claim. JDHP's claims system is only capable of capturing 3 diagnosis codes. All the diagnosis codes were not recorded in the claims

processing system for 4 hard copy claims and 1 electronic claim. (024436976, 035436159, 035538679, 101115864, M03413320)

Management's comments: John Deere Health concurs with the finding, but has a process in place to rectify the issue. John Deere Health will be implementing a new claims processing system in 2003 called Facets. Under this new system, all the required diagnosis codes will be captured on medical and hospital claims. Our previous claims processing system was not capable of storing all diagnosis codes submitted.

Of the 34 hard copy claims tested, claims processing lags could not be ascertained for 11 claims. For 8 claims, there was not a date-received stamp. (033427156, 034128152, 034835140, 034837959, 035336714, 035436159, 0355386679, 100537563) For 3 claims, the date-received stamp on the paper claim was not legible. (105937043, 035037791, 035336542)

Management's comments: John Deere Health concurs with the finding, but has subsequently resolved the issue. Prior to August 6, 2001, claims were hand date stamped. The received date on claims without date stamps could have been misstated by as much as three days. However, with the implementation of a scanning, imaging and document flow system in August 2001, the encoded claim received date reflects the actual mailroom received date. The download into the claims processing system does not change the received date from the actual mailroom received date to the date of the download.

K. Electronic Claims Capability

Section 2-18. of the TennCare contract states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment . . . ."

Section 2-2.g. of the TennCare contract required the MCO to move to electronic billing no later than January 1, 1997. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively. JDHP has implemented an electronic billing option for claims submission by providers. JDHP was in compliance with the TennCare contract. Of the 60 claims tested, 26 were filed electronically.

L. Weaknesses in Mail Room Controls

JDHP did not establish immediate control of claims received in its mailroom. Claims are not counted or logged when received in the mailroom. Claims are assigned a batch number only after they are entered into the claims imaging system, Entrendex. It is noted that JDHP does initiate control over the claims after their entry into the Entrendex system, but these controls would not find claims that were misrouted between receipt in the mailroom and the download in the system.

JDHP no longer affixes a date stamp to all claims received in the mailroom. Claims are now encoded as received on the date that the Entrendex system downloads them into the claims processing system, not the date the claim was actually received by JDHP. This practice may misstate the received date in the claims processing system by as many as 3 days. As a result, the claims processing time lags may be understated by as many as 3 days.

Management's comments: John Deere Health concurs with the finding, but has subsequently resolved the issue. Beginning in August 2001, a new incoming claims process was implemented, consisting of a scanning, imaging, and document flow system. Mailroom procedures require the placement of a cover sheet identifying the type of claim to be scanned along with a claim count and the date of mailroom receipt. Mailroom and scanning operations are under the direction of one supervisor and are physically across the hall from each other. Mailroom personnel have control of the claims until transferred to the scanners or the scanning staging area (file cabinets). Scanning procedures require personnel to match the scan date with the mailroom received date. Generally, scanning is completed on the same date as claim receipt. Once the claim is scanned, the system is capable of tracking the status of the claim.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES

A. Weekly Claims Processing Reports

The November 10, 2001, weekly claims processing report was selected for review and JDHP was requested to provide supporting documentation for this report. JDHP had not properly completed this report. All claims that have not been completely adjudicated must be included on this report. JDHP did not report claims that were not considered clean. Further, JDHP did not include on this report those claims that had been released for payment by the system but not yet paid by the system.

Management's comments: John Deere Health does not concur with this finding. The weekly claims processing report does include claims not considered clean as

well as claims released for payment but not yet paid. The report also includes claims pended for possible adjustment. (JDHP has not yet been able to confirm a date for this reporting logic.)

TDCI Rebuttal: In an interview with the Manager of Claims Performance and a Financial Analyst from JDHP, TDCI was specifically informed that the report used in the creation of the weekly claims processing report did not include claims with a "claim status of 01 – awaiting check printing." In addition, the financial analyst indicated that as she reviewed claims listed as over 60 days in process, she would remove any claims which were awaiting adjustment. This process removed claims that were not "clean."

B. Provider Appeals

At the on-site visit in Knoxville, TN, the provider appeal logs maintained by JDHP were reviewed. Examiners selected 9 appeals for review.

The documentation maintained in the provider appeal files is inadequate to support the transactions surrounding the appeal process. None of the files tested contained documentation related to the final decision of JDHP. Of the 9 provider appeal files tested, 6 files did not contain the original appeal filed by the provider and 1 appeal was recorded as being received after the date the worksheet was generated.

Management's comments: John Deere Health concurs with the finding, but has subsequently resolved the issue. Beginning in August 2001, with the introduction of a new document imaging and retention system, John Deere Health captures complete documentation on provider appeals electronically. The initial appeal, with any additional information submitted, and any mid-review or denial correspondence from John Deere Health is scanned into the system. If a claim is approved for additional payment, details of the adjustment are also captured in the same system.

C. Provider Manual

The provider manual offers written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. A review of JDHP's Policy and Procedure Manual revealed no weaknesses.

D. Provider Agreements

The examiners reviewed the files maintained by the TennCare Division of TDCI to ensure that JDHP had filed and received approval for provider contracts in effect during the examination period.

The following provider contracts templates were recently filed and approved by the TennCare Division on 12/20/00:

- John Deere Ancillary Provider Agreement
- John Deere Hospital Provider Agreement
- John Deere Network Provider Agreement

A review of provider contracts on file revealed that JDHP was using the approved contract.

In addition to the agreements listed above, JDHP had a provider agreement for the provision of pharmacy services which had not been updated recently. This contract was reviewed for compliance with Section 2-18 of the TennCare contract and was found to be out of compliance with the following 29 sections of the TennCare contract:

2-18.c.	2-18.f.	2-18.k.	2-18.l.
2-18.m.	2-18.n.	2-18.o.	2-18.r.
2-18.s.	2-18.t.	2-18.u.	2-18.w.
2-18.x.	2-18.y.	2-18.aa.	2-18.bb.
2-18.dd.	2-18.ee.	2-18.ff.	2-18.gg.
2-18.hh.	2-18.ii.	2-18.jj.	2-18.kk.
2-18.ll.	2-18.mm.	2-18.nn.	2-18.oo.
2-18.pp.			

Management's comments: John Deere Health concurs with the finding, but is in the process of resolving the issue. John Deere Health has submitted an updated pharmacy provider agreement template to the Department of Commerce and Insurance for approval. We are currently awaiting feedback from the department.

TDCI Comment: On February 21, 2003, TDCI received JDHP's request for approval of its pharmacy provider agreement. The TennCare Division of the Department of Commerce and Insurance is currently reviewing this agreement.

E. Subcontractors

1. Compliance with TennCare Contract

A. During the examination period, JDHP had subcontracts in place with Doral Dental, Davis Vision and Quality Transportation. The TennCare Bureau confirmed that JDHP had recently submitted the Doral Dental subcontract for approval in accordance with Section 2-10 of the TennCare contract.

The Davis Vision and Quality Transportation subcontracts were submitted with JDHP's original application for a Certificate of Authority and had not been revised or resubmitted to the TennCare Bureau since that time. A review of these subcontracts for compliance with the TennCare contract revealed that they were not in compliance with the following provisions of the TennCare contract:

Quality Transportation

- Enrollees not identified as the intended third-party beneficiaries. (Section 1-4)
- No requirement for subcontractors to maintain records for 5 years. (Sections 2-9 and 2-13)
- No requirement for subcontractor to make all records available for review, audit or evaluation. (Section 2-9 and 2-12)
- No language related to the assignability of transportation and claims processing. (Section 2-17)
- No language prohibiting the suggestion that children be placed in State Custody. (Section 2-17)
- Inadequate language regarding contract termination. (Section 4-2)
- Required EPSDT language not present. (Section 2-18.nn.)

Davis Vision

- Enrollees not identified as the intended third-party beneficiaries. (Section 1-4)
- No requirement for subcontractors to maintain records for 5 years. (Sections 2-9 and 2-13)
- No requirement that claims processing subcontractor cooperate with the State and its subcontractors. (Sections 2-9 and 2-12)

- No requirement that claims be processed in accordance with Sections 2-2.h., 2-9.g. and the Tenn. Code Ann. § 56-32-226(b).
- No language related to the assignability of transportation and claims processing. (Section 2-17)
- No language prohibiting the suggestion that children be placed in State Custody. (Section 2-17)
- Required EPSDT language not present. (Section 2-18.nn.)

Management's comments: John Deere Health concurs with the finding, but is in the process of resolving the issue. John Deere Health has submitted an updated subcontract with Davis Vision to the Department of Commerce and Insurance and to the Bureau of TennCare for approval. We are awaiting feedback from both entities. Additionally, John Deere Health is in the process of updating the Quality Transportation subcontract. As soon as the updated subcontract is available, we will submit it to DCI and TennCare for review and approval.

TDCI Comment: As of March 3, 2003, the proposed Davis Vision subcontract had been returned to JDHP for additional language necessary to comply with the Contractor Risk Agreement.

B. Per the weekly claims status reports submitted by JDHP, the subcontractors processed claims in compliance with Section 2-18 of the TennCare contract. However, a review by the examiners revealed that JDHP did not have a formal method to verify the claims processing efficiency and Title VI compliance of its subcontractors.

Management's comments: JDHP concurs with the finding

2. Compliance with Subcontracts

Examiners tested all payments made to subcontractors between January 2001 and June 2001.

- All 24 of the capitation payments were made in accordance with the subcontracts.

- JDHP did not always pay subcontractors timely based on the contract requirements for non-capitated payments. Of the 12 payments to Doral Dental, 8 (66.6%) were not paid in accordance with the

contract requirements. JDHP's contract with Doral requires that payment must be paid "with an electronic wire transfer within 48 hours of receipt of invoice." In each of the 8 instances mentioned above, JDHP did not make payment within the required 48 hours.

Management's comments: JDHP concurs with the finding

F. Title VI

Effective July 1996, Section 2-25 of the TennCare contract required JDHP to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various JDHP staff and a review of policies and related supporting documentation, JDHP was found to be in compliance with Section 2-25 of the TennCare contract.

G. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann. § 56-11 Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer or health maintenance organization subject to registration requirements and standards adopted by statue or regulation in the jurisdiction of its domicile which are substantially similar to those contained in this section and § 56-11-206(a)(1)." JDHP is a "foreign insurer" in Tennessee and is required to file a similar registration with the State of Illinois; therefore, JDHP is exempted from Tenn. Code Ann. § 56-11-205.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of JDHP.